Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
LEHIGH VALLEY ANESTHESIA

Respondent Name
COMMERCE & INDUSTRY INSURANCE COMPANY

MFDR Tracking Number
M4-11-0202-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 7, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are part of the trauma team at the facility and are therefore entitled to be paid at 100% under current workman's comp regulations."

Amount in Dispute: $1,426.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed CRNA, . . . The payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. The modifier to by used for current procedure identification is QX, which was the modifier used on this statement of charges."

Response Submitted by: Chartis, 4100 Alpha Road, Suite 700, Dallas, Texas 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2010	Anesthesia Services	$1,426.68	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 172 – PAYMENT IS ADJUSTED WHEN PERFORMED/BILLED BY A PROVIDER OF THIS SPECIALTY.
   - 97 – Payment is included in the allowance for another service/procedure.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Pennsylvania to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that "To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 . . . (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The applicable Division conversion factor for calendar year 2010 is $54.32. Reimbursement is calculated as follows:
   - Procedure code 01952 performed on March 22, 2010 has a base anesthesia rate of 5 units. Documentation supports 287 minutes of anesthesia. This amount divided by fifteen and rounded to the nearest decimal is 19.1. The sum of the base units and time units is 24.1. This amount multiplied by the Division's conversion factor of $54.32 results in a payment amount of $1,309.11. The provider billed the services with modifier code -QK, which indicates medical direction of anesthesia services. Per Medicare payment policy, payment for medical direction of anesthesia services is reduced by 50 percent of the allowance for the service performed by the physician alone. 50% of the payment amount results in a maximum allowable reimbursement (MAR) of $654.56.
3. The total recommended payment for the services in dispute is $654.56. This amount less the amount previously paid by the insurance carrier of $733.32 leaves an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	November 25, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief

Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.